DOCUMENT RESUME

ED 187 053 EC 124 318

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TITLE Creative Approaches to Compliance with P.L. 94-142 for H/H Programs: Under the Law, Who Is to Be Served and by Whom?
PUB DATE Apr 80
NOTE 19p.; Paper presented at the Annual International Convention of The Council for Exceptional Children (58th, Philadelphia, PA, April, 1980, Session T-63). Best copy available.

EDRS PRICE MF01/PC01 Plus Postage.
DESCRIPTORS *Compliance (Legal); *Delivery Systems; *Homebound; Home Instruction; *Hospitalized Children; *Models; Nontraditional Education
IDENTIFIERS *Education for All Handicapped Children Act

ABSTRACT

The rights of hospital/homebound children under P.L. 94-142 (the Education for All Handicapped Children Act) are considered, and a model in which service is delivered through a full-time instructor whose sole job responsibility is teaching students in homes and hospitals during school hours is seen to be most favorable. Other delivery alternatives considered are the use of part-time teachers or hourly employees, the combination of full- and part-time teachers, the after school teacher who is contracted by the district on an hourly basis to provide instruction after the normal school day is completed, the "School to Home System" which consists of a hookup between a classroom and the student's home using the telephone, and the teleclass in which a telephone conference enables the teacher to reach several students at one time in a teaching situation similar to that in a classroom. Advantages and disadvantages of each model are pointed out. (SBH)

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# CREATIVE APPROACHES TO COMPLIANCE WITH PL 94-142 FOR H/H PROGRAMS

## Under the Law, Who is to Be Served and by Whom?

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Some ambiguity seems to exist regarding the inclusion of Home/Hospital students under the regulations of Public Law 94-142. Section 601(c) of the law states "It is the purpose of this act to assure that all handicapped children have available to them ...a free appropriate public education.." This is also quoted in section 121a.1 of the regulations which states that "The purpose...is: (a) to insure that all handicapped children have available to them a free appropriate education which includes special education and related services to meet their unique needs".

Under section 121a.14 special education is defined as "specially designed instruction at no cost to the parent to meet the unique needs of a handicapped child, including classroom instruction, instruction in physical education, home instruction, and instruction in hospitals and institutions." As comment (1) of 121a.14 states, "The definition of 'special education' is a particularly important one under these regulations, since a child is not handicapped unless he or she needs special education..The definition of 'related services'..also depends on this definition, since a related service must be necessary for a child to benefit from special education. Therefore, if a child does not need special education, there can be no 'related services', and the child (because not 'handicapped') is not covered under the Act." Certainly this leaves no doubt that the regulations specifically list home instruction and instruction in hospitals as special education.

The regulations further define handicapped children as those "children evaluated...as being mentally retarded, hard of hearing, deaf, speech impaired, visually handicapped, seriously emotionally disturbed, orthopedically impaired, other health impaired, deaf-

blind, multihandicapped, or as having specific learning disabilities, who because of those impairments need special education and related services".

Other health impaired is defined by the regulations as "limited strength, vitality, or alertness, due to chronic or acute health problems, such as heart condition, tuberculosis, rheumatic fever, nephritis, asthma, sickle cell anemia, hemophilia, epilepsy, lead poisoning, leukemia, or diabetes which adversely affects a child's educational performance". These children all are commonly found in home and hospital programs.

Also the orthopedically impaired "means a severe orthopedic impairment which adversely affects a child's educational performance. The term includes impairments caused by congenital anomaly (e.g., clubfoot, absence of some member, etc.), impairments caused by disease (e.g., poliomyelitis, bone tuberculosis, etc.), and impairments from other causes (e.g., cerebral palsy, amputations, and fractures or burns which cause contractures)." These children also frequently require home and hospital instruction.

Multihandicapped means "concomitant impairments (such as mentally retarded-blind, mentally retarded-orthopedically impaired, etc.), the combination of which causes such severe educational problems that they cannot be accommodated in special education programs solely for one of the impairments." These children too appear quite often in home and hospital programs.

In addition children who are seriously emotionally disturbed frequently require home or hospital instruction. Other handicapped children are also included when a temporary physical problem (e.g., a broken leg, etc.), or surgical procedure necessitates placement

in the home or hospital instruction program.

Many "other health impaired" including those mentioned and others, such as cystic fibrosis, arthritis, etc., may require intermittent service. In periods of remission many health impaired children may be absorbed into the mainstream and require instruction in the home or hospital only during active periods of the disease or problem.

Some children, such as kidney dialysis patients, could best be served by a combination of mainstream and Hospital/Homebound placement. They need the socialization of the mainstream but also need home or hospital instruction on dialysis days. Placing the child 100% in either program greatly increases the handicapping aspect of the ailment. This is frequently true for many of our students who have "good and bad" days, such as those having leukemia, sickle cell anemia, asthma, cystic fibrosis, arthritis, etc. This issue must be addressed if we are to provide "appropriate" education for these children who are unquestionably "health impaired".

Section 504 of the Rehabilitation Act of 1973 takes a broader view and defines a handicapped person as one who has "a physical or mental impairment which substantially limits one or more major life activities, has a record of such an impairment, or is regarded as having such an impairment" (84.3j). Even, however, with the more limited definition, it would seem clear that many children requiring home or hospital instruction would definitely be included in the Act.

Additionally the 3 - 5 and 18 - 21 handicapped population if needing home or hospital instruction would be included unless this is inconsistent with state law, practice or court order. Incentive

grants have been established to assist in the education of handicapped children aged 3 - 5 (121m), and some states may choose to reach some of these children, particularly the profoundly mentally retarded, through instruction in the home under this section of the Act. Also the state's entitlement under section 611 of the Act may be used for children from birth through age twenty-one (121m). Many states are therefore developing 0 - 3 programs for handicapped children, and some will be in the home or hospital.

Using instruction in the home as a starting point may eventually provide an excellent bridge for the handicapped child and his parents to use in moving from the protected home environment to the school environment and eventually to the mainstream. There is a widely held belief that early education is beneficial to the handicapped child. In fact "Congress established incentive grants in the recognition that when education begins at the earlier stages of development (1) benefits are maximized, (2) additional or more severe handicaps may be prevented, and (3) greater long-term cost effectiveness is realized." (121m, p.42474)

Thus we see the Hospital/Homebound Program serves a varied population of children definitely covered by PL 94-142 as well as another population from the regular program with short term disabilities.

As this Hospital/Homebound population is virtually invisible, the public and even school districts may not be as aware of all their needs and problems as they would be if these children were gathered in one building as their more fortunate classmates are. Also the true character of the Hospital/Homebound population is

masked by the misconception that Hospital/Homebound programs serve children with temporary disabilities (the broken leg syndrome).

Therefore, part of the responsibility of assuring that Hospital/Homebound students receive a free, appropriate public education as defined by PL 94-142 belongs to the Hospital/Homebound teacher. This teacher is often the only representative of the educational community to see the child. Thus the H/H teacher is often the only one in a position to know which needs are being met and which needs are not being met and to articulate these needs in terms of the Law.

The regulations not only include hospital and home instruction but also imply inclusion in the funding mechanism as well. Under section 121a.126, data is required regarding "the number of other additional personnel needed and the number currently employed in the State, including...home-hospital teachers,...the salary costs of those personnel...the number and kind of facilities needed for handicapped children...including...hospital programs"(b).

Further, section 121a.551 Continuum of alternate placements states, "(b) The continuum required under paragraph (a) of this section must: (1) Include the alternate placements listed in the definition of special education...(instruction in regular classes, special classes, special schools, home instruction, and instruction in hospitals and institutions)..."

Therefore, it is clear that the PL 94-142 regulations require that home and hospital students be included in any interpretation of those covered under this Law and also that children covered by the Law be given a free apprpriate public education even if it

means rethinking some of our existing procedures, such as dual enrollments for the intermittently ill or deciding how best to serve the needs of a 0 - 3 population.

For those children presently receiving free public education at home or in the hospital, the word "appropriate" has a wide variety of both interpretations and proponents of different philosophies. The many variations on the delivery of instruction to the home and hospital can generally be lumped into several delivery models.

The most widely favored model is the fulltime instructor whose sole job responsibility is teaching students in homes and hospitals during school hours.

To understand why this model is most favored, one must consider the general characteristics of the home and hospital population. These students are suffering emotional stress from traumatic illness or impairments. Their capacity to learn is affected by medication, surgery, and extended medical care. Some are facing death. The needs of these students are very different from those of regular classroom students. Sick children are usually at their lowest ebb of efficiency in the late afternoon and must be taught when they are best able to handle it. Scheduling must be worked around therapy sessions, dialysis, doctor appointments, medication, and generally their individual needs.

Socially these children look forward to after-school hours as this is the only time that long term ill students have for peer association and the closest many will ever get to the mainstream. Also brothers and sisters come home from school and family life begins - a very important plus for these students. Father is home;

TV is on; general confusion reigns. It is a good, healthy, normal time and should not be intruded upon by the school system.

These students also have special personal needs. The child facing death needs the opportunity to verbalize his fears and feelings with a professional who has been through this experience with many other children and who knows when to talk and when to listen. The parents also make heavy use of the teacher at such times. This teaching skill only comes from an expertise developed over long experience. Students must often be helped to accept life in a bedroom or other restricting situation, for example: the newly paralyzed student who has suffered an accident or traumatic illness. These students need more than a teacher stopping by after school to teach math for an hour. Rather, they need a comprehensive program designed to meet the total unique needs of this one individual child who is already handicapped and does not need to be further burdened with handicaps.

PL 94-142 places a priority on providing a free appropriate public education first to children who are not receiving any and second to those children within each disability with the most severe handicaps who are receiving an inadequate education. Students who must wait for a tired, harried teacher who has already taught a full day to come at a late hour of the day are not receiving the most adequate education which the district is capable of delivering. These students make no other demands on the school system. They have no cafeteria, buses, etc. They have only their teacher who should minimally have only these special students as their primary job responsibilities. It was the intent of PL 94-142 that exceptional

students should not be shunted off to the background.

The regulations under section 504 of the Rehabilitation Act of 1973 deal with non-discrimination on the basis of handicap and basically require that recipients of Federal funds provide equal opportunity to handicapped persons; for example, they must meet the needs of handicapped students to the same extent that the needs of nonhandicapped persons are met. Students not given the opportunity to be schooled during the school day would not be provided the equal opportunity to the same extent as the nonhandicapped student.

Although PL 94-142 makes no mention of who shall provide special education and related services, it does address several related issues. The word "appropriate" would seem to leave the model used to the discretion of the interpreter. It does require inservice training for special educational instructional personnel as well as procedures to insure that all personnel necessary to carry out the purposes of the act are qualified (121a.380).

Section 504 of the Rehabilitation Act of 1973 states not only that the quality of service must equal that of service provided to nonhandicapped students but also that the teacher of the handicapped student must be trained in the instruction of persons with the handicap in question and appropriate materials and equipment must be available (Subpart D,23).

In addition handicapped students are to receive program options, such as art, music, vocational education, homemaking, etc.; non-academic and extracurricular services, such as counseling, recreation, athletics, special interest groups and referrals to agencies as needed; and physical education, specially designed if necessary(121a305).

These goals would seem to be more likely accomplished by a fulltime staff who has no other educational responsibilities but to assure an "appropriate" education to these home and hospital students. Also the fulltime delivery model allows a more comprehensive on-going program to handle annual reviews, develop vocational and other programs specially designed for these home and hospital students, and build an accumulation of materials and equipment that have proven successful in this special teaching situation. Certainly many of the problems encountered in teaching children in the home and hospital are recurring ones common to this field, and the fulltime staff draws on a wide range of experience and expertise gained over years of providing this particular special education.

The only disadvantage of this model is that it is perhaps the most expensive, but PL 94-142 addresses this issue and provides for the hiring of additional home-hospital teachers(121a.126).

A second model for providing home instruction would be the use of parttime teachers or hourly employees. Qualified teachers who prefer not to teach fulltime due to personal reasons are often available and provide a viable solution for small districts in particular. Hourly employees usually have adequate time for preparation and flexibility of scheduling instruction as these teachers have limited hours of responsibility.

Among the advantages of this model are qualified personnel in all subject areas can usually be found and the number of teachers can fluctuate with the number of students. These teachers too are available in the morning hours which is so important in many cases. Some small districts even give contracts to partime staff which

gives them some job security and assures the district that they will be available as needed. Some districts employ these teachers for half the day in another position (i.e., gifted, one-half time, home-hospital, one-half time).

One very good staffing pattern combines full and parttime teachers. This model overcomes the disadvantages of all parttime staff by providing the continuity, commitment, and opportunity for long range planning. At the same time this model provides the opportunity of increasing the staff at peak enrollment periods and of hiring as needed specialists in such fields as Latin, computer technology, etc., if no fulltime staff member has expertise in the required area.

A fourth model is the after school teacher who is contracted by the district on an hourly basis to provide instruction after the normal school day is completed. This can be advantageous in that the teacher may either be the student's teacher or have daily contact with the student's teachers. The after school teacher also has direct contact with the student's peer group, which can be a definite benefit in some cases.

This model does not provide instruction at the optimum teaching time nor does it provide an instructor whose primary job responsibility and interest is serving the homebound or hospitalized student. This education seems neither appropriate nor equivalent to service received by the nonhandicapped. It certainly would not suffice as a handicapped student's total educational experience though it may be acceptable for nonhandicapped children who are out of school for a brief period.

Other models already in use dependon technological equipment which may even become more sophisticated in the future.

The first of these is known as the "School to Home System" and consists of a hook up between a classroom and the student's home using the telephone. This is referred to as teleteaching (Flinck, 78) and is reported to be the oldest mode of educational use of the telephone. It was first introduced in 1939 for students who for some reason, such as illness, could not be present in the classroom for a long period of time. (Rao and Hicks, 72) There is a lack of evaluative studies which may be due to the fact that few students participated, but most writers regard the method as very successful.

The telephone has been used for a variety of reasons in many teaching experiments with isolated students in junior colleges, adult education, correspondence education, parent education, exceptional student education, etc.

A Swedish study outlines four methods which are referred to as Teleteaching, Telelecture, Dial Access, and Teletutoring. (Flinck, 75) Teleteaching is described above as the "School to Home System" and requires a special hook up for each student between the home and school but does permit two way communication, and the student listens in to his class. Queensborough Community College (New York) reported in 1975 that forty homebound students were enrolled in fifty-six different day and evening programs employing portable conference phones but stated that this method was very costly.

Dial Access consists of taped lectures which the student may dial and request at will. (Bobin, 75)

Telelecture may be a teacher lecturing via telephone and

speakers to a group of students located at another place or at several different places, or it may be several places linked to each other for group discussion. The study by Rune Flinck reports positive feedback and evaluations and notes the inexpensiveness. In addition on-campus control groups showed no differences in achievement.

The main disadvantage, of course, is the lack of face to face encounters, but many studies cited by Flinck report the method was effective with reference both to achievement and attitude. Flinck's sources also point up both the great economy in time and money and also the value of giving instuction in small and frequent doses. Kennard and Shilman in "Group Services with the Homebound" (Kennard, 79) report that the lack of face to face was not a barrier, and the results were very positive. A Brooklyn, New York, study shows positive results in socialization using long term homebound students grades 9 - 11. (Kolis, 68)

The Teletutoring model usually involves one student and one teacher using the telephone as a means of communication. This method is often used as part of a correspondence course or supplemented by printed materials and/or home visits. (Stevenson, 75) Flinck reports it as successful in adult education with students achieving as well as the on-campus control group. The Kentucky Project utilized this to deliver instruction to severely developmentally retarded children from birth to age six living with their families in sparsely populated and geographically isolated areas. (Aeschleman, 78) The Telepac Project in Utah uses the telephone and programed materials to provide instruction to severely handicapped children and to their parents in rural areas. In fact, the

parent education and the use of parents as a basic treatment resource is a major component of their program. (Hofmeister, Hertlein, Stile, 76)

A widely used model, the teleclass, adopts some features of all the telephone methods here mentioned. This program makes use of the the telephone conference call to enable the teacher to reach several students at one time in a classroomlike teaching situation. This is accomplished through the use of a console installed in a central location which is wired by the telephone company to the normal telephone service. The teacher then places into the console small plastic cards which then connect her line to all these children at the same time and permits the children not only to receive instruction but also to respond to and discuss with the other children. In this way many children spread out over a large distance may be involved in a group instruction situation.

This method of teaching Hospital/Homebound children is not only financially feasible but also offers a mainstreaming opportunity for children who might otherwise never have any mainstreaming possibilities.

Many districts throughout the country have already successfully implemented such a program. The oldest such program was started in Los Angeles County in 1963. Ohio and California have developed program standards at the state level. Some other large population centers that have successfully employed this technological advance in Hospital/Homebound teaching are New York City, Baltimore County and Duval County in Florida. All programs find it more financially feasible in giving adequate instruction to a large

number of children; however, most use it as a supplementary program. Usually children on the program are still assigned to one home base teacher who is responsible for records, testing, etc., and home visits.

Some sources say that initiating rapport and maintaining attention are problems; however, they add that these problems can be overcome by using a personalized approach, employing varied teaching styles and evaluating the appropriateness of the mode of instruction. (Parker, 75) Also the technique is most effective when delivered in brief lectures and augmented by printed materials, audiovisual aids and home visits.

Because of the need to consider educational alternatives to meet rising program costs, the teleclass concept may be considered as a viable supplementary program. It would seem particularly beneficial when used in conjunction with a fulltime staff.

These varying methods are highly interesting in demonstrating the variety of models which may enable the educational system to carry out the mandate of PL 94-142 to serve all handicapped children regardless of how severe or isolated they may be. The opportunities for providing a less restrictive environment or mainstreaming, as it is sometimes called, are enormous. Students with no possibility for social interaction or school "chums" may suddenly be enmeshed in a multitude of such opportunities. Interesting specialists, such as a biologist, may visit with the students via teleclass and enter into the interaction that Flanders and others have found so important to a child's learning and growth. (Flinck, 78) Max Rafferty, past Superintendent of Public

Instruction in California, stated in his introduction to their bulletin, "Home and Hospital Instruction in California", that home and hospital students are patients as well as students and that their education is "an undertaking that requires the full effort and cooperation of both educational and medical personnel". Certainly there can be no doubt what socialization does for the spirit of homebound students, and a more positive attitude has been well documented as having concurrent positive effects on health.

Thus, there would seem not only to be no ambiguity as to whether PL 94-142 applies to home and hospital instructional programs but also to be some very obvious directions that can be taken to meet the mandate to "assure... a free appropriate public education.."

BIBLIOGRAPHY

Aeschleman, Stanley R.,Tawney, James W., Interacting: A Computer-Based Telecommunications System for Educating Severely Handicapped Preschoolers in Their Homes. Educational Technology, Oct. 1978, pp. 30-35.

Aronovici, John G., Ed., We Serve the Exceptional Child..., Los Angeles City Schools, Calif. Div. of Special Education, 1972.

Bolvin, Boyd M., Using Technology to Serve Learning Needs of the Community. New Directions for Community Colleges, Spring 1975, pp. 33-38.

Carsello, Carmen J., Morrison, Joseph F., Technology Brings Instruction Home. Educational Technology: Teacher and Technology Supplement, Oct. 1972, p. 69.

Flinck, Rune, Correspondence Education Combined with Systematic Telephone Tutoring. Lund University, Sweden, Dept. of Education, 1978.

Flinck, Rune, The Telephone as an Instructional Aid in Distance Education: A Survey of the Literature. Lund University, Sweden, Dept. of Education, 1975.

Hertlein, Forest J.C., Project Telepac: The Telephone as an Instructional Communication Device for Parents of Handicapped Children and Youth. Chicago C.E.C.,1976.

Hofmeister, Alan M., Atkinson, Charles M., The Telepac Project: A Service Delivery Model for the Severely Handicapped in Rural Areas. Chicago C.E.C., 1976. Also Utah State University, 1975.

Kennard, W.W.,Jr., Shilman, R.P., Group Services with the Homebound. Social Work, July 1979, pp. 330-332.

Lolis, K., Evaluation of a Method of School-to-Home Telephone Instruction of Physically Handicapped, Homebound Adolescents. New York City Board of Education, June 1968.

Naples, Victor J., Todd, J.H., Orthopedically Handicapped Children in Ohio Public Schools. Ohio State Dept. of Education, 1968.

Outland, R.W., Gore, B.E., Home and Hospital Instruction in California. Calif. State Dept. of Education, 1969.

Parker, L.A., Baird, M.A., Humanizing Telephone Based Instructional Programs. Wisconsin University, 1975.

Program Standards for Special Education and Legal Dismissal from School Attendance. Ohio State Dept. of Education, 1973

Public Law 94-142, Education for All Handicapped Children, 1975.

Resource Manual for the Development and Evaluation of Special Programs for Exceptional Students, Volume II-H Homebound/Hospitalized. Tallahassee, Florida: Bureau of Education for Exceptional Students, 1979.

Schmeller, K.R., Attending College When You're Homebound. Community and Junior College Journal, April 1975, pp.28-29.

Section 504 of the Rehabilitation Act of 1973. Final Regulations

Stevenson, M.L., Otto, A.C., Telephone Teaching and Testing. Journal of Home Economics, March 1975, pp. 27-28.

Stile, S.W., Atkinson, C.M., Project Telepac: Packaged Home Instructional Materials for Parents of the Severely Handicapped: A Concept Analysis. Chicago C.E.C., 1976.

Teacher's Reference Guide to PL 94-142. Washington: N.E.A., 1978.